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(281) 362-5580 FAX: (281) 719-5175

| *****CLINICAL USE ONLY***** | | |
|---|---|---|
| Date: | MRN: | |
| Name: (Last, First) | | |
| Height: | Weight: | BMI: |
| B/P: | Pulse: | |
| Waist to Hip Ratio: | | |

## Welcome to SynergenX Health Clinic!

| SynergenX Health & Wellness Clinic | | Patient Registration Form |
|---|---|---|
| **Name** *(Last, First, M.I.):* | ☐ M ☐ F | **DOB:** |
| **Age:** | **E-Mail Address:** | |
| **Address:** | | |
| **City:** | **State:** | **Zip:** |
| **Home Phone Number:** ( ) | | **Cell Phone Number:** ( ) |
| May we send you a text message reminder the day before your appointment? ☐ YES ☐ NO | | |
| **How did you hear about SynergenX Health Clinic?**<br>☐ Billboard ☐ Coupon ☐ Direct Mailing ☐ Employee ☐ Internet ☐ M.D./Doctor ☐ Other<br>☐ Newspaper ☐ Patient/Friend ☐ Radio ☐ Walk-In ☐ Rheumatic Fever ☐ Magazine | | |
| **Did someone Refer you to SynergenX Health Clinic?** | | **Which Doctor, if any, referred you?** |

**Goal Weight:** __________ **When was the last time (if ever) you were at that weight?** __________

## Patient Health History

Have you had Comprehensive physical exam within the last 12 months? ☐ Yes ☐ No
Have you had an EKG in the last 12 months: ☐ Yes ☐ No
If Yes was it normal? ☐ Yes ☐ No

**Women Only:**
Date of last menstruation?
Are you currently on birth control?
Date of last well women exam:
Date of last mammogram:
Are you pregnant, trying for pregnancy or breastfeeding? ☐ Yes ☐ No

## Allergies to Medications

| Medication Name | Reaction |
|---|---|
| | |
| | |

## Prescribed Medications & Over-the-Counter drugs, dietary Supplements (including vitamins, inhalers etc)

| Medication Name | Strength | Frequency |
|---|---|---|
| | | |
| | | |
| | | |

| History of Cardiac Disorder / Event ☐ NONE | |
|---|---|
| ☐ Myocardial infarction | Date: |
| ☐ Cerebrovascular accident | Date: |
| ☐ Thrombosis / Embolism | Date: |
| ☐ Coronary artery bypass graft surgery / CABG | Date: |
| ☐ Aortic valve disorder | Date: |
| ☐ Mitral Valve Disorder | Date: |
| ☐ Endocarditis | Date: |
| ☐ Pericarditis | Date: |
| ☐ Cardiomyopathy | Date: |
| ☐ Cardiac conduction disorder (AV block, Bundle Branch block, Mobitz type II AV) | Date: |
| ☐ Cardiac arrhythmia (Atrial fibrillation/flutter, Paroxsymal supraventricular tachycardia, etc.) | Date: |
| ☐ Heart failure (congestive heart failure, etc.) | Date: |

| **Past Medical History** ☐ NONE | **Check any that you ever had or been diagnosed with any below** | |
|---|---|---|
| ☐ Prior Hormone Replacement Therapy ______________________ | ☐ Diabetes I ____________ | ☐ Anemia |
| ☐ Sleep Apnea: ______________ | ☐ Diabetes II ____________ | ☐ Hemochromatosis |
| ☐ Snoring | ☐ Hypothyroidism | ☐ Bleeding disorder: ____________ |
| ☐ Chronic Kidney Disease | ☐ Enlarged Thyroid | ☐ Obesity |
| ☐ Abnormal Liver function | ☐ Enlarged Prostate | ☐ Cottonseed Allergy |
| ☐ Heart Disease: ____________ | ☐ Hx of prostate cancer | ☐ History of Seizures |
| ☐ High Blood Pressure: ________ | ☐ Hypogonadism | ☐ Cancer __________________ |
| ☐ High Cholesterol ____________ | ☐ Depression ______________________ | ☐ Cardiovascular Disease |
| ☐ Peripheral artery disease | ☐ Anxiety | ☐ Blood Clot (DVT/Pulmonary Emboli) |
| ☐ Chronic Lymph node enlargement | ☐ HIV | ☐ Chest Pain |
| ☐ Inability to father children despite unprotected sexual relations > 1 year | ☐ Mumps | ☐ Heart Attack |
| ☐ COPD | ☐ Acid Reflux | ☐ Heart Failure (CHF) |
| ☐ Insomnia | ☐ Gout | ☐ Stroke |
| | ☐ Headaches (frequent) | ☐ Other: __________________ |
| | | ☐ Other: __________________ |
| **FOR WOMEN ONLY** | | |
| ☐ Endometriosis | ☐ Fibroids | ☐ Polycystic Ovarian Disease (PCOS) |

## Social History

| | |
|---|---|
| Exercise | How often are you physically active for 20 minutes or longer?<br>☐ Never ☐ 1-2 x/week ☐ 3-4 x/week ☐ >5 x/week |
| | Which type(s) of exercise do you do? (check all that apply)<br>☐ Walking ☐ Running ☐ Weights ☐ Other ______________________________ |
| | Do you have any barriers that limit your ability to safely exercise? ☐ Yes ☐ No<br>Please check all that apply:<br>☐ Work ☐ Family ☐ Energy level ☐ Medical Condition ☐ Pain ☐ Motivation ☐ Other _________________ |
| Caffeine | Rank your caffeine intake: ☐ High ☐ Medium ☐ Low ☐ None |
| | What do typically drink during the day?<br>☐ Water ☐ Juice ☐ Tea ☐ Cola ☐ Diet Cola ☐ Coffee ☐ Other:__________________________ |
| | How many cups/cans per day? ____________ |
| Alcohol | Do you drink alcohol? ☐ Yes ☐ No |
| | If yes, what kind? ☐ Beer ☐ Liquor ☐ Wine |
| | How many drinks per week? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6 |
| Diet | Are you dieting? ☐ Yes ☐ No |
| | If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No |
| | How many meals do you eat on an average day? |
| | Rank your salt intake ☐ High ☐ Medium ☐ Low |
| | Rank your fat intake ☐ High ☐ Medium ☐ Low |

**Please check the appropriate column for each of the following questions:**

| | Never | Rarely | Sometimes | Often | Almost Always |
|---|---|---|---|---|---|
| Does your family eat meals together? | | | | | |
| Do you read the food labels/nutritional information when you shop for food? | | | | | |
| Does your nutritional information influence your decision to buy/eat certain foods? | | | | | |
| Do you eat in front of a TV? | | | | | |
| Do you eat with others? | | | | | |
| Do you eat when you are stressed? | | | | | |
| Do you eat when you are anxious? | | | | | |
| Do you eat when you are lonely? | | | | | |
| Do you eat when you are not hungry? | | | | | |
| Do you eat when you are bored? | | | | | |

## Lifestyle

How many hours do you typically sleep at night? _________

How long does it typically take you to fall asleep? _________

How many times, on average, do you wake up once you fall asleep? _________

Do you wake up most mornings feeling well rested? ☐ **Yes** ☐ **No**

Has anyone ever told you that you snore? ☐ **Yes** ☐ **No**

## Weight History

| Weight History |
|---|
| 1. What is the main reason you decided to lose weight? |
| 2. When did you begin gaining excess weight (give reasons if known)? |
| 3. What do you think is the main cause of your weight problems? |
| 4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible. |
| 5. Is your spouse, fiancé, or partner overweight? |
| 6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there? |
| 7. List any food allergies: |
| 8. What foods do you avoid? |
| 9. What foods do you crave? |
| 10. Do you awaken hungry during the night? |
| 11. What are your worst food habits? |
| 12. What are your snack habits? |
| 13. Rate your body from 1 to 10. How would you describe your body? |
| 14. If you could change one thing about your body, what would it be? |
| 15. What do you feel will be your obstacle(s) to successful weight loss? |
| 16. What is your typical breakfast? What time? Where? With whom? |
| 17. What is your typical lunch? What time? Where? With whom? |
| 18. What is your typical dinner? What time? Where? With whom? |
| 19. Add any additional comments you think would be helpful to the doctor. |

Do you have a personal of family history of blood clots or any clotting disorder? ______________________________

If you answered yes to any of the preceding questions regarding the gallbladder, ovarian cyst or blood clots, please read the following statements and sign in acknowledgement:

**Gallbladder or gallstone statement:**

I understand that any pre-existing gallbladder dysfunction or gallstones I have (whether or not I am aware of it) may become exacerbated due to the low-fat nature of the HCG Diet Program or as a consequence of the rapid weight-loss. This may result in the need to have my gallbladder surgically removed.

__________________________ __________________
Patient Signature Date

**Ovarian Cyst / Polycystic ovarian syndrome statement:**

I understand that if I am predisposed to ovarian cysts or polycystic ovarian syndrome, there is an increased risk of a cyst rupture due to ovarian stimulation from the HCG hormone, which may or may not require surgery.

__________________________ __________________
Patient Signature Date

**Blood Clots statement:**

I understand that HCG is a hormone that has the potential to increase the risk of blood clots in genetically susceptible people. If I have a personal or family history of blood clots, I accept this increased risk and agree to take asprin and other recommended supplements to try to counteract the blood clot risk.

__________________________ __________________
Patient Signature Date

## *****SynergenX Clinician Use Only*****

Physical Exam: ______________________________________________________________________________

Impression / Diagnosis:

- ☐ Overweight
- ☐ Obese
- ☐ Metabolic Syndrome
- ☐ Dietary Counseling and surveillance
- ☐ Hypothyriodism
- ☐ Elevated B/P
- ☐ Hypertension
- ☐ Abnormal EKG
- ☐ Other: ___________________________

BMI results: ICW:____ ECW:____ BMI:____ PBF:____% ECW/TBW analysis:_____

Waiste to Hip ratio:_____

EKG Results(if needed) : ___________________________________

Treatment: HCG: 23 Day / 40 Day Lipo C Inj Phentermine 37.5mg prescribed today

Recommended _____lbs of weight loss